DOCUMENT RESUME

ED 419 178 CG 028 367

AUTHOR Chambliss, Catherine
TITLE Preparing Psychotherapy Students for the New Demands of Managed Care.
PUB DATE 1998-00-00
NOTE 32p.
PUB TYPE Information Analyses (070)
EDRS PRICE EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Contracts; *Counselor Training; Ethics; *Health Care Costs; *Health Maintenance Organizations; Health Services; Innovation; Legal Responsibility; Mental Health; *Orientation; *Psychotherapy
IDENTIFIERS Case Management

ABSTRACT

The wildly varying utilization and quality control practices that make up "managed care" make it difficult to generalize new rules and requirements. Information that can aid counselor trainees in understanding the demands of managed health care is presented. The text explores the following questions: (1) "What do managed care companies want?" and (2) "What does managed care expect from behavioral health care providers?" The paper also explores some of the expectations that operate consistently across different managed care companies. It introduces the managed care mindset as "the future belongs to those who balance both quality and cost." It is claimed that psychotherapists must understand the domains of both administrators and clinicians in this new world of care. The ten key concepts underlying managed behavioral health care treatment direction, duration, dosage, and delivery are presented. Also provided are case management expectations of managed health care organizations, ethical psychotherapy treatment preferences on the basis of optimizing rather than maximizing care, and the idea of working responsibly to pare treatment. Partnering with managed care companies requires therapists to empathize and view problems from both the managed care and psychotherapy perspectives. Psychotherapists are advised to pick their clinical battles with increasing care and focus energy on cases where the most good can be done efficiently. (Contains 32 references.) (MKA)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 419 178

PREPARING PSYCHOTHERAPY STUDENTS FOR THE NEW DEMANDS OF MANAGED CARE

Catherine Chambliss, Ph.D.

Ursinus College

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

C. CHAMBLISS

1998

2A

WHAT MANAGED CARE EXPECTS FROM PROVIDERS
Essential Skills for Participating in the Evolution

What do managed care companies want? What does managed care expect from behavioral healthcare providers? Becoming a successful managed behavioral healthcare provider can seem to be an overwhelming challenge, fraught with ambivalence. Adopting the requisite therapeutic framework will enable you to work more effectively in a managed care context. Understanding what these companies value and expect can also help you make the decision if this type of work would be right for you. The following paper explores the answers to these questions in light of the experiences of successful managed care providers.

The wildly varying utilization and quality control practices subsumed by the label "managed care" make it difficult to generalize about the new rules and requirements governing effective practice. MCOs present providers with a constantly shifting patchwork of practices and standards generated by individuals with different underlying motivations. However, there are some regularities across all MCOs that offer useful guidance to those preparing themselves to work as clinicians under managed care. This paper will explore some of the expectations that operate consistently across different managed care companies.

Alongside the new expectations is discussion of common stumbling blocks that make it difficult for many therapists to adjust to the world of managed care. Many providers complain that there is a conflict between the way therapists have been trained to approach therapy, and the demands of managed health care. Therapists need to resolve these conflicts in order to survive in the managed health care field.

The Managed Care Mindset:
The Future Belongs To Those Who Balance Both Quality and Cost

CG028367

Directions in health care management have changed, chiefly because of the much more intense focus on accountability for efficiency and value. Efficiency equals the return from the investment of time and resources.

In health care, value equals outcomes/cost, where "outcomes" is the sum of clinical, functional, and satisfaction outcomes, less the costs associated with adverse outcomes. Although the field has only started to measure these variables with any precision, and much controversy about appropriate measurement is likely to persist, it is useful to adopt this perspective in evaluating proposed services for patients.

$$\text{Value} = \frac{\text{desired outcomes - adverse outcomes}}{\text{cost}}$$

In saturated, mature managed care markets, health care delivery systems have had to work on both the numerator and the denominator, because of competition for contracts. It is often considerably easier, especially for those with short-term horizons, such as managers, who are also accountable to investors and who move around a lot in their careers, to concentrate on the denominator. If nothing else, it is easily measured. However, the future belongs to those who can balance both quality and cost.

Research by Austad, et al. (1993) on a large sample of psychologists, psychiatrists, and social workers showed that effective HMO psychotherapists tend to shed long-term psychodynamic orientations and to use more eclectic and non-traditional problem-solving short-term therapy models. Competence in brief therapy, crisis management, and treatment planning were important clinical priorities, despite the fact that the majority of respondents (60.7%) felt they had not been adequately prepared for this type of work in graduate school. These researchers recommended that MCO policies should favor selection of clinical staff whose values are compatible with the philosophy, structure and needs of the MCO.

No matter where you go, or what the organization's mission statement, if you are going to be both effective and satisfied, you need to be able to understand the worlds of both administrators and clinicians. You must span the boundaries of both roles, and see the complete picture. In addition, you want to help guide your fellow clinicians to participate actively in and push the process of developing, implementing, measuring against, and improving on clinical and utilization guidelines.

You will be more effective in working in the managed care era if you engage in what some refer to as "point of service" utilization management. This involves talking with clients in such a way that they participate in the decision making process

and assume increasing responsibility for considering cost-containment. Clinicians need to "sell" the value of less resource-intensive, but equally effective, options for diagnosis and treatment. As professionals, we have just recently become aware of the importance of seeking cost-effective ways of doing business. Our clients need to move from a position of entitlement to one of partnership, and to do that they require our guidance.

Need for Ongoing Innovation

Established MCOs and HMOs are feeling considerable pressure to hold down costs in a fiercely competitive market. We must look for new strategies for creating the future, because that is what it is going to take. Very few health care systems are thinking seriously and confrontively about where they need to be in 10 or 15 years. This is unfortunate, because we are very much in a transitional, unstable period right now.

What Managed care wants providers to offer: The Right Stuff

Several concepts are emphasized by MCOs, and are likely to shape the practice of all insurance-reimbursed psychotherapy in the future. The following list summarizes ten key case management expectations and treatment preferences of managed behavioral healthcare organizations:

Ten Key Concepts Underlying Managed Behavioral Healthcare Treatment direction, duration, dosage, and delivery

Case Management Expectations:
A. Limit treatment objectives & scope of treatment
B. Limit duration and depth of treatment
C. Provide a seamless continuum of care

1. Provision of services to enrollees according to their specific benefit plans, including a schedule of benefit exclusions:
Delimit care to services covered by the benefit plan
Delimit care according to chain of causality

2. Aim treatment at restoring baseline level of functioning.

3. Delimit care according to medical necessity:
Use the Diagnostic and Statistical Manual of mental disorders (DSM IV) nomenclature and behavioral indicators of medical necessity (e.g., dangerousness to self or others)

4. Provide services at the appropriate level of restrictiveness, intrusiveness, and intensity
Provide brief, outpatient care whenever possible

5. Use a variety of mental health resources
Use group as well as individual treatment formats

Use various professionals and paraprofessionals.
Refer to community-based service alternatives when appropriate
Provide smooth transitions across different levels of care
Reduce fragmentation along the continuum of care
Coordinate care with primary and other health care providers
Facilitate the case management process
Avoid duplication of services or inefficiencies in service delivery.

Treatment Preferences for those Conducting Psychotherapy:
Manage care ethically: Optimize rather than maximize
A. Adopt empirically justified methods
B. Provide accountable treatment of demonstrable quality
C. Favor cost-effective settings and methods

6. Select treatment interventions according to research
Apply the Common factors findings
Apply Solution-focused findings
Apply the Brief Therapy Findings
Apply empirical findings about specific treatments
Select methods strategically based on time limits on care
Provide brief, problem-oriented, goal-focused treatment

7. Use an accountable treatment process that demonstrates quality
Develop concrete, realistic, written treatment plans with measurable goals and measure treatment outcomes
Organize patient care around standardized treatment guidelines and preferred practices, to ensure that care is consistently delivered, is evaluated by objective standards, and is based on clinical signs and symptoms.

8. Use less expensive treatment settings and methods whenever appropriate
Use outpatient services whenever possible
Use inpatient services to manage crises & stabilize, basing length of stay on clinical need, as opposed to rigid programmatic expectations.
Differentiate substance abuse from mental health problems before initiating treatment; Use variable length of stay substance abuse inpatient treatment or detoxification, with length of stay based on clinical need, as opposed to being programmatically driven.
Use intensive outpatient programs for the treatment of substance abuse.
Use group and self-help treatment modalities
Use paraprofessional and peer helpers
Offer couples and family systems interventions
Employ pharmacotherapy to the appropriate level for your discipline

9. Know and use preventive strategies to reduce future costs

Partnering with managed care:

10. Collaborate in the mutual effort to optimize treatment quality while containing costs
Attempt to maximize patient satisfaction
Facilitate patients' acceptance of limited care
Accept fiscal accountability, through capitation or incentive structures that reward choice of the least expensive but still adequate form of treatment.
Accept discounted fee arrangements with preferred providers.
Accept ongoing evaluation of providers' performance in delivering services in accordance with the expectations of the managed care organization. Provider profiling is used to determine the relative effectiveness of different clinicians in meeting the objectives of the MCO (efficient, cost-effective delivery of high quality treatment).
Conform to administrative procedures in documenting care

These ten concepts underlying managed behavioral healthcare are derived from the need to provide quality care while continually curbing costs. Criteria for treatment direction, duration, dosage, and delivery have been developed with these joint ambitions in mind.

Case Management Expectations

A. Limit treatment objectives & scope of treatment
B. Limit duration and depth of treatment
C. Provide a seamless continuum of care

Providing services to enrollees according to their specific benefit plans, including a schedule of benefit exclusions, is central to viable care management. Without such limitations, there would be no way for MCOs to predict or control service delivery, which would make appropriate pricing impossible. Working within the constraints of particular policies may be unfamiliar, but must be mastered.

A policyholder's medical benefit package represents an agreement by the insurer to treat certain medical conditions with specific treatment alternatives under a given set of conditions in exchange for a fixed dollar premium. It is not an entitlement to whatever treatment interventions the patient or clinician feels might potentially be reasonable. For example, most health insurance policies do not reimburse for academic testing, even though most child and adolescent clinicians view academic testing as an essential part of the evaluation process of an academically underachieving student. Clinicians should understand each patient's benefit plan and organize treatment within its limitations. Doing so requires conscious inclusion of informal helping avenues. Clinicians contribute to their patients' health and welfare when they direct them to the school or community for uncovered services, just as they help their patients when they

personally provide services that are covered under the patients' medical benefit.

Typical mental health conditions covered under managed care tend to be those that require an immediate intervention:

- Emergency care -- for patients who may be dangerous to themselves or others.
- Acute care -- for short-term life crises.
- Marital or family conflict -- especially if abuse is involved.
- Brief solution-focused problem solving.
- Assessment and referral for chronic mental illness -- screening for long-term therapy.

Delimiting care according to chain of causality can be challenging for providers, but managed care companies expect this. Our aim in managed care treatment is restoring the patient's baseline level of functioning, rather than promoting self-actualization. After justifying the patient's need for treatment in terms of medical necessity, providers are expected to resist the temptation to broaden the scope of treatment to include non-medically necessary objectives. Providers need to constrain the care they provide so that it addresses the justifying condition, and goes no further. What you are treating now must be related to the initial referral question. You may identify several relevant factors that operate in a given case, but you are expected to confine treatment to issues related specifically to the preliminary presenting diagnosis. If someone initially presents with panic attacks, it is inappropriate to extend treatment beyond those interventions needed to deal with that problem, and end up doing unrelated counseling, such as marital therapy, even though the individual might arguably be in need of marital counseling. This can be especially important in dealing realistically with personality disorders in managed care context.

Therapists often see one delimited problem a patient presents as symptomatic of other more general problems in a patient's life. Managed health care requires a narrowing of emphasis on the presenting problem, to the exclusion of other ancillary problems. HMOs and MCOs contract to ameliorate specific psychiatric symptoms, rather than to defray the cost of counseling aimed at fostering personal growth and expanded consciousness. Instead of succumbing to the temptation to overtreat, aim treatment at returning the patient to their best previous or premorbid level of functioning. Resist the temptation to pursue more lofty goals than contracts stipulate!

Managed care expects providers to delimit care according to medical necessity, and to use the Diagnostic and Statistical Manual of mental disorders (DSM IV) nomenclature and behavioral indicators of medical necessity (e.g., dangerousness to self or others). The concept of medical necessity emerged in the 1980s when payers and their agents turned to utilization review of each

treatment decision in an effort to contain costs (Kuder & Kuntz, 1996). Determining medical and psychological necessity represented an effort to standardize and eventually publicize the criteria by which payers commit to paying for services and decide on the level of care at which these services should be delivered. Providers need to organize their treatment plans around these published criteria if they hope to maximize services and reimbursement.

It is increasingly incumbent on providers to demonstrate the appropriateness of their providing services in each and every particular case. Increasingly we are asked to justify our decision to intervene in terms of medical necessity. While in some instances we can point to physical risks that psychotherapy will reduce, more often we must couch medical necessity in terms of how the presenting problem is impairing the client's ability to perform some necessary major life function (work, family, or social). Medically necessary mental health care is defined in terms of a comparison of the client's capacity to function in a healthy manner with and without treatment.

Behavioral indicators of medical necessity (e.g., dangerousness to self or others) are also increasingly being emphasized in making treatment authorization decisions. In recent years, MCOs have been moving away from a diagnosis-based system of reimbursement. Instead, their priority is risk-management, and accordingly their decisions about when to extend outpatient treatment beyond the stipulated minimum are based on evidence of client dangerousness. Suicidal and homicidal evidence count heavily, as do behaviors that could escalate and result in the need for costly inpatient stays in psychiatric hospitals. Behavior matters more than diagnosis.

This does not mean the diagnostic system has become obsolete, but rather that we must make different use of the diagnostic system than we did in the past. DSM IV describes the modal symptoms and behavioral risks associated with various disorders. In discussing utilization with MCO representatives, we need to translate diagnostic categories into behavioral terms relevant to the criteria being used by the MCO. The important thing is the way that symptomatic behavior is immediately being manifested in ways that pose hazards. Someone with a longstanding eating disorder may or may not be in jeopardy. Reviewers want to understand the current level of threat, and want treatment described in terms of how it will address the immediate needs of the client. MCO contracts cover services that effectively reduce psychiatric symptoms; curing the underlying disorder is not the objective, per se.

Since many individuals who seek therapy are best described as having problems in living, rather than formal disorders, many candidates for therapy fail to meet the diagnostic criteria that are required for reimbursement of services. This often presents ethical dilemmas for the therapist. Survey data suggests that many providers have exaggerated the seriousness of clients' conditions in order to satisfy insurance criteria (Scholl et al.,

1996). This frequent practice has the real risk of compromising the trust between reviewers and providers, making mutual collaboration that much less likely. Resist the temptation to manipulate diagnosis!

Limiting the duration and depth of treatment without compromising the quality of care requires managed care providers to "work smarter". Clinicians must understand the impact of time limits on care, because brief interventions are favored at every level of care. Although the fact is that psychological interventions have always been short term (Garfield, 1986), in modern behavioral practice they must be short term by design, rather than by default (Budman & Gurman, 1988).

In many respects, behavioral healthcare is coming to resemble the practice of primary care medicine. Typically, patients come for help with acute problems or acute exacerbations of chronic problems. Treatment is concluded when the presenting symptoms are resolved. Although each individual episode may be short term, the treatment relationship may endure over a long period of intermittent treatment, managed care contracts permitting. Emphasis will continue to be on providing services at the appropriate level of restrictiveness and intrusiveness, using brief, outpatient care to the greatest extent possible.

Managed care offers patients the greatest advantages when a seamless continuum of care is provided. Such a continuum recognizes the shifting needs of consumers, and is designed to flexibly accommodate these changing requirements most cost-effectively. Using a wide variety of traditional and nontraditional mental health resources can meet patients needs while holding costs down. Providing group treatment, encouraging use of self-help strategies, and using paraprofessional and peer-helpers can all reduce spending while assuring patients the support and guidance they need.

Referring patients to community-based service alternatives when more costly alternatives are unavailable is also common with managed care. Providing smooth transitions across different levels of care, and reducing fragmentation along the continuum of care are important for patient satisfaction. Since many of the disorders we are trying to address are stress-responsive problems, adding to the patient's confusion by failing to coordinate different elements of their care will typically exacerbate symptoms, possibly increasing need for care. Coordinating care with primary and other health care providers can help us achieve the goal of providing more holistic, integrated solutions for patients' problems.

Managed care companies rely on case management to ensure appropriateness of care and avoid duplication of services or inefficiencies in service delivery. They make use of a variety of mental health professionals in addition to psychiatrists, and try to integrate community resources in their client's care.

Behavioral interventions are increasingly delivered by nonphysician clinicians and treatment teams (Burk, Summit, & Yager, 1992). Effective care requires coordinating these

different providers and the services they offer. Effective collaboration is especially important for patients with psychiatric and substance use disorders and those with psychological factors affecting physical conditions.

Closer coordination of disparate healthcare services should amplify the "medical offset" (Borus, Olendzke, & Kessler, 1985; Cummings, 1996), because patients who have been treated well for mental health and substance abuse problems should require less expensive medical-surgical care.

Currently twenty percent of our patients consume 80 percent of our mental health care dollars (Patterson, 1994). Case management represents an attempt to focus particular attention on high-cost, high-risk patients. Providers often view case management as a time-consuming and unnecessary burden, but it is becoming increasingly important as we struggle to allocate scarce resources more efficiently and humanely. Case managers contribute to the treatment process when they link providers, integrate treatment plans, and make systematic use community resources.

Facilitating the case management process by nurturing good relationships with other members of the treatment team will both help the patient and improve your overall clinical effectiveness. In the past, communication problems often resulted in redundancies and duplication of services at best, and countertherapeutic sabotaging at worst. Managed care demands that providers have the maturity to work collaboratively in finding the optimal solutions for patients, and resist the tendency to join patients in disparaging other "inferior" helpers, even though it can fuel a therapist's ego to see him or herself as "the only one who really understands. The only one who knows. The only one who can help."

Continuous quality improvement programs can assist you in assuring that consumers' needs are being promptly and appropriately addressed. These programs attempt to improve quality by identifying indicators that are routinely monitored. These indicators often focus on the five dimensions of high quality healthcare: availability, accessibility, acceptability, accountability, and appropriateness. Incorporating ongoing means of assessing your success in satisfying these criteria can assist your organization in detecting problems that can be remedied. Routine assessment of these indicators helps orient staff to important aspects of their work, and motivates them to provide more patient-centered services.

Availability and accessibility indicators include the number of telephone callers who hang up before their call is answered, the length of delay before the initial appointment, and the user-friendliness of the benefit design. Patient satisfaction surveys and comparison of treatment protocols against standards are indicators of acceptability. Accountability and appropriateness can be demonstrated by outcomes data, utilization patterns, and actual cost savings for the payer. Organizing clinical and management services with the goal of continuous quality

improvement will foster steady improvement in the nature of care your organization is able to provide its patients.

Many mental health providers are unaware of the amount of behavioral health care delivered through employee assistance programs (EAPs) (Masi & Caplan, 1992). When EAP counselors refer a patient to outside providers for ongoing work, they may continue to serve as the patient's advocate in the workplace. Effective collaboration between mental health providers and the EAP can prolong employment, enhance performance, and improve the employee's functioning in the home setting. Working effectively with employee assistance programs can enhance your success in being a managed care provider.

Costs of worker's disability compensation run roughly $70 billion annually, including those for medical care for injured workers, payments to employees during periods of short-term disability, and compensation to employees for permanently disabling conditions. Presently, employees' health care insurance and disability insurance are separate products, but many experts anticipate a future integration of these benefits. This integration will alter the role of clinicians, as they increasingly will be asked to help reduce the incidence and impact of job-related illness and facilitate each employee's return to productive work. Understanding disability, worker's compensation, and other workplace issues can also make you more effective in providing managed care psychotherapy.

Treatment Preferences for those who conduct Psychotherapy
Manage care ethically: Optimize rather than maximize care

A. Adopt empirically justified methods
B. Provide accountable treatment of demonstrable quality
C. Favor cost-effective settings and methods

Managed care expects therapists to use the empirically justified treatment methods. Applying psychotherapy research findings conscientiously will help you to provide the cutting-edge, high quality care that the best managed care companies prefer.

Managed care organizations and behavioral group practices are accumulating vast amounts of data about treatment and outcome. Analysis of this information will reveal which treatments are most effective for which clinical problems and diagnoses in the hands of which providers. Clinicians must be willing to abandon less effective treatments and familiar theoretical positions in the face of persuasive, scientifically valid evidence.

Managed care providers are encouraged to provide services with a goal of optimal, rather than maximal, care. Over-treatment is recognized as both wasteful and frequently countertherapeutic. The primary aim of managed mental healthcare is restoring the client's baseline level of functioning as efficiently as possible, by disrupting their natural support system as little as

possible.

MCOs require that we conceptually distinguish between supportive, conversational contact and directive, focused therapy. The former conversational activity can often be provided through less expensive avenues (including peer support groups, and the informal support network comprised of the client's family and friends). Although we as clinicians may pride ourselves in our knack for skillful encounters with clients in need of conversational support, a large body of research has failed to show the superiority of trained, experienced clinicians over untrained, paraprofessionals in providing conversational counseling (Dawes, 1994).

On the other hand, this same research also demonstrates that in doing brief therapy, the professionals are best (Berman & Norton, 1985). Apparently our training as clinicians makes us uniquely valuable in helping people make changes efficiently. It seems reasonable that MCOs should wish to use our services because of this special competence. Although we may enjoy conversational therapy, and perceive a widely experienced need for this type of social interaction in our increasingly alienating society, extended conversational therapy is not the treatment of choice in the eyes of MCOs, and if it were, we would be less valuable to them, because we have yet to prove our supportive conversational services are better than those available less expensively through alternative sources.

Working Responsibly to Pare Treatment

Working effectively within the system demands that we take responsibility for making the most prudent choices about length of treatment. We must not perseverate and keep clients that are not responding to our methods in ineffective treatment. We must recognize the difference between desirable and necessary treatment. And we must make use of our expertise where it makes the greatest difference, and delegate forms of helping that can be provided less expensively by others to others. We need to learn to make more optimal use of the limited resources that will be at our disposal, and this requires adopting a new mind set.

Working for and with MCOs dramatically alters the nature of psychotherapy, and the role of the therapist. Managed care providers need to be part lawyer, case manager, agent of the court, business person, referring agency, personnel manager, disciplinarian, and negotiator. Therapy will no longer be the simple expedient of sitting down with a client and discussing the client's problems, keeping notes, and collecting fees.

The nature of psychotherapy is changing drastically as a result of the growth of managed care. Many of the formerly dominant conversational therapeutic approaches are being used with an increasingly narrow segment of the population, and delivery of these less directive methods is increasingly constricted by managed care policies. Understanding the revised and expanded expectations of therapists associated with managed

care can help you succeed and prosper. Adopting the required mindset will expedite your work and facilitate more effective collaboration with managed care company representatives.

Increasingly, providers are expected to justify their choice of interventions in terms of the research literature on empirically supported forms of psychotherapy. Treatment protocols and plans need to demonstrate the link between the presenting problem and the selected intervention strategies. The techniques being provided must be appropriate to the needs of the client, and reasonable given the demands for time-limited therapy.

Selecting treatment interventions according to the research literature can seem daunting at first. One way of demystifying the process is outlined at the end of this chapter, and is referred to as the Speed Sequence. This strategy uses the findings from four research domains to help clinicians pare treatment by finding the least necessary but sufficient type of intervention. The Common factors findings emphasize how the majority of treatment success seems to derive from aspects of the patient and the generic helping relationship, rather than from any specific intervention technique a therapist may offer. Given this, it is sensible to try to elicit these universal agents of improvement as quickly and as inexpensively as possible. The Solution-focused findings suggest that highlighting patients' strengths and competencies in therapy, rather than their weaknesses and dysfunctions, may result in faster recovery. When these techniques suffice, they offer a low-cost, low-risk form of intervention that has much to recommend it. The Brief Therapy findings highlight the advantages associated with focusing therapeutic work on clear, measurable goals, and avoiding communications that implicitly convey the expectation that therapy must be arduous and prolonged in order to be useful. The efficacy research on specific treatments developed to address particular diagnoses can be valuable in providing efficient solutions for those plagued with stubborn symptoms that fail to yield to more general types of therapy. The empirical literature on specific forms of psychological treatment permits you to use your patient's diagnosis as a basis for choosing highly specific interventions proven to be effective in similar cases.

Therapists who use a narrow theory to guide their therapy will run into difficulties, as their approaches will often fail to meet the requirement that providers avail themselves of what the literature has established to be the most efficacious form of treatment for a particular disorder. Providers are expected to be eclectic and scientifically-grounded, and to work independently of their allegiance to a particular school of thought. Managed care organizations generally expect providers with a mastery of short-term, focused therapy, diagnostic evaluation skills, and capacity for collegial interaction among psychiatrists, psychologists, and social workers (Lazarus, 1995). Don't be limited by a narrow theoretical orientation!

Providing an accountable treatment process of demonstrable

quality requires that providers develop concrete, realistic, written treatment plans with measurable goals, and actively and objectively measure treatment outcomes. Organizing patient care around standardized treatment guidelines or protocols can help to ensure that care is consistently delivered, is evaluated by objective standards, and is based on clinical signs and symptoms.

Psychotherapy is increasingly assessed in terms of the impact patients experience and report on various outcome and satisfaction measures. Visible outcomes are a requirement of managed care; they seek to quantify the changes in patients that accompany therapy, no longer trusting clinicians' self-appraisal of their work. Providers that contribute to the process of demonstrating the effectiveness of the MCO in meeting their clients' mental health needs promptly and efficaciously will be favored. Provider profiling intends to describe each clinician in terms of their effectiveness in resolving particular types of client problems.

As a result of managed care, there is growing interest in treatment outcomes and client satisfaction. As competition among managed care organizations grows, and companies increasingly market themselves in terms of quality and "value added", consumer satisfaction is expected to become an increasing priority. Providing consumer-centered, respectful care that meshes with the desires and values of the client will be valued. Retention of payors is in the managed care organization's best financial interest, so they are highly motivated to keep those they insure content. Articulating the value of the care you provide both to patients and to their families is in your best interest, because this will ultimately serve to perpetuate the MCO's contract to continue to provide services to this payor.

Most patients seem to want the short term treatment managed care has been promoting. This may be because long-term therapy may have costs beyond the financial, such as iatrogenic harm to the patient's self concept and their natural support system. The MCO focus on consumer satisfaction provides a check on unbridled greed. In a 1998
survey examining why organizations choose to contract with a particular HMO, two hundred and eighty-three corporate executives were asked their major reason for selecting and evaluating an HMO. Access and geographic coverage topped the list, followed by member patient satisfaction (Drug Benefit Trends, 1998).

The Heart of Managed Care: Focused Treatment Planning

Treatment targets

Managed care therapists are asked to identify target symptoms and develop a treatment focus. The treatment focus may reflect patients' chief complaints and life experiences (Strupp, and Binder, 1984; Budman, 1992; Davanloo, 1978; Malan, 1976; Gustafson, 1984), their internal thought processes (Beck, Rush, et al. 1979), their interpersonal relationships (Klerman, Rounsaville, Chevron, et al. 1984), or their search for solutions

(De Shazer, 1988).

These targeted symptoms and treatment foci should be translated into treatment goals. Therapists will need to avoid "rambling" therapy by developing definitive goals early on that will direct therapy, rather than letting goals and concerns evolve naturally as part of a therapeutic process.

A clear, defensible treatment plan is the crux of good managed behavioral healthcare. Treatment plans should be designed to achieve these specified goals. Most clinical work with the patient should be intentionally directed at these specific goals. An episode of care is complete when the goals have been achieved, even if additional issues might be addressed in a longer treatment.

Therapists need to focus on observable and measurable changes in the client's life, and the emphasis will be on getting the client to make discrete changes rather than processing emotional issues or discussing a variety of concerns. Methods for measuring changes in presenting problems will be needed in order to demonstrate treatment efficacy.

Therapy increasingly resembles corporate brainstorming sessions, in which solutions to problems are mutually generated and the patient is encoruaged to experiment with changes after the session. The thoughtful, digressive discussions of various sundry life concerns, and the mutual search for understanding and insight into the causal factors that shaped the client's life, are activities that are generally not considered part of the treatment services covered in managed care. These mainstays of long term therapy may have value (the 1995 Consumer Reports study shows that clients find these pursuits helpful), but they go beyond what managed care companies contract to do.

In the interest of speed, therapists need to make quick assessments of the client's problems, and talk in practical, everyday terms that the client understands to get to heart of the problem. Problems can no longer be couched in vague, clinical terms, and veiled in intimidating jargon. Reviewers demand clear specification of problems, including reference to particular client behaviors. The general diagnosis matters less than the current specific manifestations of the diagnosis.

Although there are a large number of different forms of managed care, they share an insistence on the development of a clear and focused treatment plan. The fact that brief treatments will be used for most patients challenges clinicians to design treatment plans that offer the patient the greatest return for time and resources invested. Realistic plans are aimed at returning the patient to adequate health and functioning, rather than curing underlying disorders and other conditions. Patients should be encouraged to take pride in even modest changes, and reassured that continued growth is expected to occur outside of treatment. In providing brief care, leaving the door open for intermittent treatment can be useful; patients may be invited to return for additional work on the current issues if that proves necessary in the future.

Until recently, a clinician's training and theoretical bias dictated his or her treatment plan (Schreter, 1997). Payers find this method of treatment choice too random and unreliable. In an effort to standardize care, professional groups, including the American Psychological Association and the American Psychiatric Association, are developing treatment guidelines and preferred practices. Increasingly, attention to scientific data and outcome studies will improve the quality of guidelines that can help to direct optimal, efficient care.

Utilization of standardized treatment guidelines or protocols is valued, in order to ensure that care is consistently delivered, is evaluated by objective standards, and is based on clinical signs and symptoms. Use of the Diagnostic and Statistical Manual of mental disorders (DSM IV) nomenclature, and written treatment plans with clear, measurable goals are also emphasized by most managed care companies. Psychotherapy standards of care currently exist only in primitive form. At present, the process of developing psychotherapy standards of care is still in its infancy. The sketches of treatment protocols presented in the chapters that follow are based on work that future research will help to elaborate far more fully.

Providers need to articulate how they will handle cases of depression, anxiety, PTSD, marital and chemical dependency issues, and demonstrate the efficacy of the interventions they use. Designing justifiable treatment plans for various DSM IV diagnoses can increase your effectiveness in working with managed care groups. Familiarity with the outcomes literature described in chapters that follow will help you considerably in developing empirically based treatment plans.

Managed behavioral health care (MBHC) is reshaping clinical practices by focusing on the goals of efficacy and efficiency. Norman Winegar (1993) maintains that standardization of products and services, and increased productivity, will be two inevitable outcomes of the MBHC, along with new clinical service marketing strategies, increased oversight of treatment plans and service delivery, better accountability for effectiveness and client satisfaction; and increased services within a coordinated network of health care professionals and facilities.

Using less expensive treatment settings and methods whenever appropriate is central to managed behavioral healthcare. Outpatient strategies are decidedly favored over more expensive inpatient treatment.

Managed mental healthcare organizations have this strong preference for outpatient-based treatments, wherever they are clinically appropriate, because of their desire to reduce exorbitant hospitalization expenses. In providing outpatient are they emphasize utilization of brief, solution-focused counseling approaches, aimed at restoring function as expediently as possible. MCOs are also interested in providers with skills in crisis management and stabilization, in order to stave off the need for inpatient care for those with severe mental illnesses.

Responses to the needs of the severely and persistently mentally ill and the substance abusing population are different with managed care delivery systems than with traditional systems. Managed care companies use inpatient treatment sparingly, primarily for assessment and stabilization purposes, with length of stay based on objectively measured clinical need, as opposed to being programmatically driven (i.e., all substance abusers require the identical 30 day inpatient stay program). They use variable length of stay substance abuse inpatient treatment or detoxification services. Many managed care companies make use of intensive outpatient programs for the treatment of substance abuse.

Services are typically provided to enrollees according to a schedule of benefit exclusions, which unfortunately many enrollees fail to comprehend fully until they find themselves faced with the need for uncovered services. This can put providers in a challenging situation, because while in an ideal world they might hope for all services to be covered, if they sympathize with the patient and criticize the MCO, this might increase patients' dissatisfaction and threaten the MCO contract. Providers must balance their need to advocate for the patient's interests with a realistic appraisal of sufficient care. Managed care often directly involves providers in fiscal accountability through capitation or incentive structures. In these cases, providers must starkly balance their own financial stake in minimizing costly treatment with their ethical obligation to provide necessary care.

Hospital care is now used for stabilization and patient safety. Full-day hospital care is now limited to patients who are so dangerous to themselves or others or so unable to care for themselves that they can be treated only in the most highly structured settings (Schreter, 1997). In many inpatient units, the average length of stay is only five days for all psychiatric admissions. Variations on the 24-hour day, including 23-hour observation beds and three-day crisis beds, are emerging across the country. Patients are discharged to lower levels of care or back into the community as soon as they can tolerate discharge without danger.

Inpatient services are increasingly used to manage crises and stabilize patients, so they and others are not in immediate danger. Accordingly, discharge planning commences as soon as the patient is capable of handling the demands of less complete supervision, even though they may at that point be far from "well". Partial hospital programs, intensive outpatient programs, and supervised community living arrangements permit patients to enjoy less restrictive treatment settings while they pursue their gradual return to baseline functioning.

As more policies restrict behavioral health coverage to crisis intervention and stabilization, rather than treatment, it is increasingly incumbent on providers to incorporate plans for community referral into their treatment. Dwindling resources at the community mental health level force us to make more creative

use of peer support programs and educational mechanisms for helping clients address their social and behavioral problems.

Subscribers to these more highly delimited policies often have coverage for up to 20 sessions of outpatient therapy and 20 days of inpatient treatment, but this only covers crisis intervention and stabilization. Additional sessions beyond the initial evaluation would be authorized only if the individual was in crisis or if additional treatment would be needed to forestall a crisis.

Length of stay is increasingly based on the patient's objective, behavioral clinical need, as opposed to being programmatically driven. Variable lengths of stay in both psychiatric and substance abuse inpatient treatment have become the norm. Rather than filling beds with candidates for rigid 30-day treatment programs, providers must constantly monitor the daily progress of their patients in order to determine whether continued inpatient care is medically justified. This creates more of a monitoring and paperwork burden, but it also probably improves the patient's quality of care, because therapists must really stay on top of all their inpatient cases.

Cost consciousness compels therapists to become more open and flexible in their choice of treatment modalities. When dealing with populations of patients, group treatments frequently offer various advantages (Donovan, Bennett, & McElroy, 1981; Budman, 1992). Educationally oriented, time-limited groups can be used for stress management and skill building with patients who suffer from less severe disorders. Groups can also be designed to focus on specific issues common to members, including parenting, anxiety, depression, bereavement, and eating disorders. Open-ended long-term groups, and intensive outpatient and medication management programs, are often helpful for patients with chronic, recurrent, and characterological disorders.

Since the focus of behavioral health interventions is on facilitating efficient change, inclusion of members of the patient's natural support system can frequently be advantageous. Many clinicians have found family systems interventions helpful in maximizing the change process in brief treatments (Bergman, 1985; DeShazer, 1982; DeShazer, and Molnar, 1984). Generally, if more than one person is involved in the problem, it can be useful to bring all of them into the office. Including family members usually increases the therapist's understanding of both the problem and potential resources for its solution. Improved communication increases the likelihood of effective collaborative problem-solving, and reduces family members suspicions that therapists are colluding unfairly with patients and blaming others unreasonably for the patient's problems.

Therapists will need to rely more on the natural, informal sources of social support in the client's life, and the client's own resources in therapy. Rather than being a setting where the client will work out all of his or her problems, the therapist will be more of a director of change and a consultant to the

client, placing greater responsibility on the client to work independently or along with friends and family. The tendency to see psychological problems as requiring extensive help that can be exclusively provided by highly trained experts can be an obstacle to developing cost-effective forms of helping. Avoid counterproductive denigration of informal helpers!

Employing pharmacotherapy yourself, or working closely with a physician who can prescribe psychotropic medications, can expedite treatment. Appropriate use of psychotropic medications can provide symptomatic relief and enhance the impact of other treatment interventions for responsive patients. Confronted by the demand for efficiency, clinicians should maximize their ability to use psychotropic medications in their treatment planning. Clinicians who are not physicians must be able to recognize the indications for pharmacotherapy. Willing psychiatrists must be prepared to integrate their medication management into treatments provided by others.

Knowing how to use preventive strategies to reduce future costs distinguishes the most forward-looking managed care providers. Investing responsibly in preventive measures will have the greatest impact on future behavioral healthcare costs.

Capitation creates incentives for providers to institute preventive programs to reduce the development of disorders that are costly to treat. Preventive strategies are expected to assume a more prominent role in health care due to an increasing focus on populations instead of individual patients. This public health perspective encourages screening programs to identify patients at risk and those in the early stages of disorders, in order to stave off costly aggravation of problems. This orientation also promotes treatments that reduce the negative impact of health conditions.

The National Committee for Quality Assurance has identified several populations as targets for preventive interventions: children from abusive families, adolescents with high-risk sexual behavior, and adults who abuse substances or who have mood disorders (National Committee for Quality Assurance, 1996). The development of cost-effective prevention programs requires thoughtful consideration of a variety of factors that influence the value realized by such efforts. The savings from prevention are a function of the cost of preventive services, their rate of success, the false positive rate in identifying the target service recipients (resulting in individuals receiving unnecessary preventive services), and the false negative rate (resulting in missed cases whose problems will not be prevented and will later emerge, demanding treatment).

One intangible benefit of prevention programs is the avoidance of suffering associated with the development of a potentially preventable condition. This needs to be balanced against possible deleterious consequences of receiving unnecessary preventive services, given the unavoidability of false positives; this cost is another intangible.

The greatest savings from preventive programs occur when the

at-risk group can be accurately identified (few false positive and false negatives), and services provided during a brief critical period which obviates the need for later, long term care. Early intervention programs for children with pervasive developmental disorder represent one such case where early intensive treatment generally produces sizable savings long term.

Partnering with managed care companies requires empathizing with them and viewing problems from both their perspective and your own. Many providers complain about a sense of competing loyalties: to the MCO, to their traditional way of doing psychotherapy, and to their patients' best interests.

Therapy through managed care involves a three-way contract among therapist, client, and managed health care company. The goals of all three are not always aligned with each other, and the therapist often needs to negotiate the therapy contract within this atmosphere of conflicting goals. Doing so in an ethically responsible, balanced way requires considerable skill. Providers serve as representatives of the managed care company, and should share the organization's philosophy and feel comfortable being committed to the success of the organization. However, this loyalty to the managed care company can compete with a desire to serve as an advocate for the client.

It can be destructive to align with the client against the managed care company by suggesting that the client should be entitled to a wide variety of benefits that have not been forthcoming. It seems far more appropriate for providers to adopt the position that managed care company's contract can legally restrict the availability of services, and that the mature response of clients to these restrictions is to become as informed as possible about them in advance, and to operate as constructively as possible within these reality-based boundaries. It is generally unhelpful to promote the client's rage, which is often based on unreasonable expectations, and the immature, illogical reasoning that there should be no restrictions on care now because at one point their employer or they could afford coverage that was more inclusive.

Collaborating in a mutual effort to optimize treatment quality while containing costs requires sympathy to MCO objectives. Their survival depends upon contract renewals. Attempting to maximize patient satisfaction and facilitating patients' acceptance of limited care will help the MCO stay in the payor's good graces, which improves the MCO's chances of renewal. While assisting negligent, irresponsible MCOs is undesirable, helping the better MCOs to thrive in the competitive marketplace can ultimately improve the quality of care and of work for providers. Help the good guys win!

Accepting fiscal accountability, through capitation or incentive structures that reward choice of the least expensive but still adequate form of treatment, is new for many behavioral healthcare providers. Accepting discounted fee arrangements with

preferred providers has become a common way for providers to assure a steady stream of referrals. Your net will be less per case, but by working with a large a secure caseload, your overall earnings will be far more secure.

MCOs also conduct ongoing evaluation of providers' performance in delivering services, in accordance with the expectations of the managed care organization. Provider profiling is used to determine the relative effectiveness of different clinicians in meeting the objectives of the MCO (efficient, cost-effective delivery of high quality treatment). Although most of us recoil with evaluation apprehension at the prospect of having our work closely monitored, it is helpful to remember that profiling will identify top performers and permit them to be rewarded. IF you are a conscientious, hard-working therapist eager on improving your skills, provider profiling may ultimately prove to be an ally.

One problem with provider profiling is that crude methods can systematically disadvantage those clinicians who work with more difficult, treatment-resistant patients. We would expect a clinician working exclusively with mildly depressed, college-educated patients to obtain higher average patient success and satisfaction scores than one working only with patients with borderline personality disorder. A fair system includes means of weighting the outcome measures for a provider's caseload according to their proportion of such difficult cases. Understanding the medical informatics systems used by your company, and working to make them clinician-friendly and meaningful is important. Trying to get the populations case-mix adjusted to allow for a fair profiling system is important. Without this, clinicians working with more treatment-resistant patients will be systematically disadvantaged by the monitoring process. We must show other clinicians and administrators how performance can be improved by judicial use of appropriate outcomes measures, and be prepared for debate when biased measurement methods distort conclusions drawn about providers.

In addition to accepting provider profiling, conforming to administrative procedures in documenting care will also make you more managed care-friendly.

A Triage Mentality Can Keep You Afloat: Evolving Criteria for Outpatient Treatment

When medical resources are scarce relative to demand, as in times of war, health professionals have long made use of a triage approach that quickly screens cases in order to determine treatment priorities. Here, we'll argue that a similar screening strategy can help you make more optimal use of your clinical resources, given the limits imposed by managed care.

Whether you're working in a capitated or fee for service system, if there are constraints on the number of sessions you can provide clients, and concomitant measures of treatment outcome are being employed, it is vital for you to have a system

for selecting those cases where you have the greatest likelihood of creating improvement, and avoiding those cases where your treatment methods are most likely to be unproductive.

With capitation, you don't dare risk squandering time where it does no good. Cases with extremely poor prognoses need to be prevented from happening in the first place, or where this is impossible, less costly forms of client maintenance or management must be developed. Your most expensive clinical services should not be devoted to cases with minimal probability of gain, lest you reduce the overall value added of the system.

With a managed fee for service system, since it is incumbent on you to demonstrate the positive impact of your services on the clients you serve, it is important to offer only appropriate treatment in each case. Cases with poor prognoses, given available treatment modalities, will deflate your overall efficacy indicators, and possibly have a negative impact on future referrals.

Screening clients is not something new. Outpatient clinicians who could afford to, always preferred to work with clients carrying certain diagnoses more so than others. YAVIS (an acronym for "ideal" therapy candidates who are young, attractive, verbal, intelligent, and successful. The obvious question: why would such a person need therapy?) clients have always been sought because they were more rewarding to work with in therapy; they changed, improved, and left happy. Whatever treatment model was used, these clients tended to get better, and thereby flattered their therapists.

But what's needed now is a new type of screening. This screening is based partially on an assessment of how much the client truly needs our services (thereby excluding many of the old YAVIS group from care that will be reimbursed) and partially on an assessment of how much the client is likely to gain from our particular mode of treatment. Both of these factors need to be considered in conjunction in order to make the best choices about outpatient care.

Need Is Not Enough

Many prospective clients need services that are not currently available. At the moment, there is no foolproof way of resolving the problem of substance abuse; studies estimate a relapse rate of over 90% following the best of currently available treatment. Dissociative Identity Disorder and Borderline Personality Disorder are increasingly diagnosed, but remain tenaciously frustrating to treat effectively.

While promising treatment approaches are being developed for these vexing problems, no method on the horizon offers a reliable fast fix. For example, in cases of both DID and BPD, when a precipitating traumatic event plays a role, new treatments such as EMDR have been used efficiently to produce some improvement (Shapiro,1995). However, while EMDR increases the client's comfort level and reduces unwanted intrusive emotion-stirring

ideation, EMDR does not quickly resolve the interpersonal struggles of most DID and BPD clients. Cognitive approaches have been applied to both populations in recent years with some success (Layton, et al, 1995), but even most advocates of these methods acknowledge that treatment is still likely to be very protracted in these cases. In reviewing the psychotherapy outcome data, Kroll (1994) states that the effectiveness of treatment for BPD has not been demonstrated; roughly 50% of BPD drop out of treatment within six months, and that 50% of those successfully being treated terminate against their clinician's advice.

Recognizing the limits of our current treatment methods can help us avoid the expense of inappropriate assignment of clients to treatment modalities that are likely to be ineffective. The old unrestrained fee for service method of reimbursement in some ways rewarded us for taking on frustrating cases with poor prognoses our techniques were ill-equipped to treat; even when long-term treatment was ineffective, we got paid. Some clinicians formed practices with a stable backbone of BPD clients who never changed much, but kept coming for years.

Some defend this use of clinical time on the basis that these BPD clients had clear need of services. It would be hard to argue otherwise; these BPD clients were distraught, lonely, people with crisis-filled lives, quite obviously in need of social continuity. The question, however, is whether weekly individual meetings with an expensive psychotherapist are the most efficient way to meet this need for support. Increasingly, MCOs are challenging us to demonstrate the "value-added" associated with treating such clients over an extended period of time.

"Pick your battles", we often admonish parents we see in family counseling; similarly, we should probably select our own clinical battles with increasing care. Focusing our energies on those cases where we can do the greatest good, as efficiently as possible, is increasingly important.

The Managed Care Clinical Decision-Making Tree

1. Evaluating Candidates for Therapy . Before seeing a client for therapy, the therapist will need to make a determination about whether insured therapy is warranted. Two areas need to be evaluated. First, are there any medical problems that may be the source of the client's problems? Secondly, is the client a substance abuser? In the first case, working with a physician may be necessary before proceeding further. In the latter case, the MCO will demand referral for 1) detoxification if required, 2) an inpatient rehab if indicated, and 3) referral to some support group like A.A. However, if psychotherapy is allowed, it may be short-term, terminating as soon as the client can continue on their own in an A.A. type group. Often, in these cases, the therapist will find him/herself working with the employer, because often these referrals are made at the request of the employer. Following through with such referrals become a

condition of employment for the client. Therefore, successful outcomes are linked to the client's keeping his or her job. Recognizing when such special contingencies are operating is important for therapists wishing to maximize motivation for efficient change.

2. Traditional outpatient "therapy proper" is only one of five options. Psychotherapy cases fall into five major areas. First, the therapist may be dealing with family issues, usually involving behavioral or other similar problems with children. In such cases, the therapist will train parents as therapeutic agents. Second, cases may involve couples issues, either negotiating differences or making decisions about staying together. Third, there are the seriously mentally ill that require medication and psychiatric care. Fourth, are the unstable yet functioning individuals who often pose risk management concerns and are long term care candidates. These create problems for MCOs, and are difficult to treat. They are what result in losing money for MCOs. They have been known to bankrupt clinics. These call for effective case management more so than conventional outpatient therapy. With these clients, therapy must often become task-oriented and somewhat coercive. Finally, there are candidates for outpatient psychotherapy proper, between a client and therapist. In such cases, therapy is pragmatic, problem-solving, and time-limited.

3. Legal and contractual issues. Managed care psychotherapists will need to be up-to-date on many legal issues that will affect therapy. These include contractual issues with MCOs, and also employers. There is often an agreement between an MCO and an employer that may require clients to be in therapy as a condition of their employment. Consequently, the therapist may be part of a disciplinary process, and in effect be reporting to the employer about the client's progress and compliance with disciplinary conditions. The implications of such a role for the conduct of the helping relationship can be quite profound. Clear communication about reporting plans, externally mandated therapeutic objectives, and the therapist's role are vital in such cases.

In addition, the therapist will often be involved in a three way negotiation involving (1) what he desires for the client in terms of sessions, (2) what the client desires, and (3) what the MCO allows. Liability issues will arise about premature discharge of a client when the MCO will not allow the client to continue in therapy even on a non-paying basis. Further, many MCOs may not want the therapist to reveal to the client the limitations placed on the therapist by the MCO. This can put the therapist in the awkward and potentially unethical position of withholding information about optimal treatment or actively misleading clients about their progress and readiness for termination.

One way of reducing this likelihood is to frame clear, measurable, short-term therapeutic objectives in the very first contact. This communicates the intent of therapy in explicit and certain terms, and clarifies the scope of treatment. At the end

of the allotted treatment period, if specific behavioral goals have been achieved, the therapist's task of presenting termination as appropriate should be easy and straightforward: our job is done. By narrowly defining the expectations of therapy from the outset, the therapist has not been deceiving in conveying the idea that therapy was completed, even if on some level a possibility exists that additional contact with the therapist could confer additional advantages to the client's wellbeing. According to managed care's definition of therapy, all was a success.

In cases where specific outlined behavioral goals have not been met, two main options exist. If these unmet goals relate to dangerous outcomes (for example, the client has been showing an escalating pattern of suicidal behavior), the clinician must critically appraise the impact of the interventions used to date. If there is evidence of progress, the clinician has a basis for requesting a treatment extension. This may be granted by the managed care utilization reviewer on the grounds that successful outpatient therapy would be less costly than inpatient alternatives. If evidence of progress is lacking, the clinician may decide that this treatment modality is unlikely ever to transform the problem significantly, and may choose to work with the case manager to develop a more appropriate treatment alternative.

When unmet goals are less serious, terminating treatment early in order to stay within managed care guidelines can actually offer some therapeutic advantages. The therapist can highlight any partial progress the client has made, and provide review materials for the client's future application of the methods of change the client has found to be most helpful. Frequently this type of self-administered follow-up treatment can help the client continue to work toward their ultimate objectives. Clients who are trying to put changes into effect across the various relationships in their lives will require a lengthy period of experimentation and practice before they feel entirely comfortable with their new way of responding to events.

However, contact with an expensive professional may not be vital during this protracted period of practice. Helping the client to plan the particular people in their natural support network to whom they will turn for feedback and support during this period of extended learning and generalization, can fill many of the same needs formerly performed by long-term therapists. A client who is learning to be more assertive with others in order to stave off panic experiences may benefit from reassurance that it is normal to encounter occasional situations that "throw you" and create a reversion to timidness, and that these episodes are an expected, temporary part of the lifelong learning process, and not a sign that all gains have been lost.

Extending therapy sessions too long can create the faulty expectation that the client will eventually reach a point of perfection, where all will always go smoothly and according to plan, and treatment continues to be necessary until that point is

reached. Helping clients recognize that many times if they can achieve their behavioral objective 75% of the time, they are doing about as well as everybody else! Ending treatment on that note is not fraudulent overselling; it's pretty realistic.

If there is no partial progress to highlight, structured termination can provide an opportunity to reflect on the therapist and client's shared frustration, and to do some trouble-shooting to evaluate an alternative set of steps the client may wish to try on their own. There are myriad reasons for a client's failure to progress during brief therapy.

There may be ambivalence about making changes because of secondary gain factors. Rather than treat this as a mysterious secret, a therapist can bring this issue to the surface in a constructive way, by showing respect for the client's difficult decision ("You want to move and make these changes, because doing so would offer these advantages, but at the same time part of you is reluctant make these changes because you would have to give up X, Y, and Z, which are understandable to want"). This honest clarification of the client's quandary may be the most appropriate outcome of therapy in some cases. Longer therapy may not be better when the client may be deeply undecided about the direction they wish their life to take. The client may find it helpful to discuss the pros and cons associated with different paths, but that type of conversational deliberation often does not require the professional services of a therapist.

Failure to progress may be due to inappropriate choice of treatment interventions. Discussing what has worked and what has not worked for the client can allow the therapist to make some new recommendations that may match the client's needs and abilities more appropriately. The pressure to achieve change as efficiently as possible can force us to detect unsuccessful approaches quickly and change course accordingly. It also forces us to become proficient at making clients feel comfortable with us. Putting clients at ease as quickly as possible is imperative, given the fact that they don't have the luxury of a drawn-out warming-up period.

Although it is admittedly frustrating to terminate a case before goals have been reached, it is important for therapists to acknowledge that they have limits, and that sometimes extending treatment would produce little additional gain. For most clients, the greatest rate of change in psychotherapy comes early on, when expectations of self and therapist tend to be highest. If we focus on the value we are adding to all of our clients' lives, it may make sense for us to put most of our professional energy into these opportunities for greatest growth, rather than to persist in cases where clients may not yet be ready to change or are unable to profit from the techniques we have currently available.

4. <u>Liability issues</u>. Therapists will have to be up to date on issues that involve risk-management. These include suicide, harm to others, and hospitalization. Further, child abuse concerns may arise, including cases where adult clients report earlier experience of abuse and cases requiring evaluation of current

child abuse. Increasingly courts demand expert opinions, and punish severely errors in judgement and failure to report.

Working With Utilization Reviewers

While utilization review (UR) can seem an impudence to experienced practitioners who have enjoyed considerable autonomy in the past, it can also be viewed as a means of moving the psychotherapy professions forward. Given the overwhelming amount of treatment research being generated today, it is unrealistic to expect busy practitioners to keep up with all of it. The UR process provides one mechanism for assuring that treatments being offered reflect the most recent standards of cares. UR Guidelines like Milliman and Robertson or Health Risk Management are not written by academics in a vacuum. They are written by real clinicians and are modified frequently by users' groups. While you may disagree with them, in justifying your deviations it is important to offer arguments with clinical and scientific merit.

If you are trying to deal with a utilization reviewer (UR), it can be helpful to keep the following suggestions in mind. They are based on a recognition that efforts to forge an alliance with managed care representatives is usually in the provider's best interest.

1. Know the specific details of the client's insurance coverage. Contact their managed care company representative and discuss your findings and your treatment plan with the reviewer early on in the treatment process. Discuss what will be the most mutually convenient way that you can keep the reviewer informed about the case. Most managed care companies will provide means of assessing the client's progress, but agreeing upon a plan for making phone or e-mail contacts with the reviewer (e.g., Is it alright to leave messages? How will receipt of messages be confirmed? Can written authorization be sent electronically to reduce wasteful phone tag?) can save you headaches down the road.
2. If you believe the UR's determination is not medically sound, keep on discussing it. Try to find out why you are disagreeing. Often when there is a disagreement, it is due to a communication problem. Ask to see the UR's "utilization guidelines". This can improve communication, and result in authorization.

3. Be flexible: ask yourself whether you are requesting something out of habit. Specifically, if the UR is requesting a shorter length of stay or a different site of treatment, see if you can look at the matter through their eyes and understand their reasoning.

4. Give the reviewer the benefit of a doubt. Assume that the reviewer really does have the patient's interests in mind. They generally believe that less intrusive, short-term treatment in the least restrictive setting works best, and have the studies to

support their position. They also see the money being spent as the patient's money (in fact it is; it is part of the compensation package provided by their employer). It is important to follow through and provide the particular services you say the patient really needs. Just as you remember your reviewers, they remember you, and keep notes of discussions about care.

5. Don't confuse a life-threatening diagnosis with a life-threatening patient status. Bulimia is life-threatening, but a particular patient may not currently have a life-threatening status. You'll need to document the current facts to show that the patient's present condition warrants the treatment you're planning now.

6. Failure of outpatient treatment is often necessary before inpatient treatment will be approved. Documenting patient behavior that shows this failure (rather than therapist feelings, accurate as they may be) is what reviewers look for.

7. Learn the criteria for admission, continued stay, and the various other levels of treatment (partial hospitalization, outpatient care, etc.) for the various conditions you treat. Learn them as well as you would if you were a reviewer, or a consultant to an insurance company. Then learn, from the reviewers, if possible, what manner of documentation -- what type and quality of case facts -- they use to make their decisions. For that matter, if you have a chance to review or consult to reviewers, seize it. You'll be amazed at what you'll learn.

8. Rely on empirical data in your case notes. "The patient reports binge/purging three times since yesterday morning," rather than "The patient is getting worse; needs inpatient stay."

9. Make sure your case management shows consistency. Diagnosis, need for treatment (client's condition), intensity of treatment planned, and intensity of treatment delivered, should all relate clearly to one another. Exaggerating the need for treatment, when coupled with routine scheduling of appointments (or even scheduled gaps in treatment), stand out like a sore thumb. A life-and-death patient condition calls for urgent action and timing from the therapist.

10. In some cases, you may need to initiate a formal appeal of a reviewer's decision. It may be that your patient has to do this, but you can help by knowing the procedure. Insurance companies have higher powered professionals to review denials and appealed claims. Overturned denials typically result from clearer documentation of the need or delivery of treatment that would have been approved. Although some managed care companies have reputations for responding to clinicians who appeal with punitive measures such as denial of subsequent referrals, the

limited empirical evidence available (Scholl et al., 1996) suggests that the majority of managed care providers do not report having had such experience. You may need to speak with the reviewer's supervisor or the medical director of the company. Newly implemented NCQA standards are expected to facilitate the appeals process in companies that formerly made it unwieldy. Familiarizing yourself with these regulations will help you use them to your advantage.

Bibliography

Austad, C., Sherman, W., & Holstein, L. (1993). Psychotherapists in the HMO. *HMO Practice*, *7*(3), 122-126.

Beck, A., Rush, A., Shaw, B., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford.

Bergman, J. (1985) *Fishing for Barracuda: Pragmatics of Brief Systemic Therapy*. New York, Norton.

Berman, J., & Norton, N. (1985). Does professional training make a therapist more effective? *Psychological Bulletin*, 98, 401-406.

Borus, J., Olendzke, M., Kessler, L., et al. (1985). The "offset effect" of mental health treatment on ambulatory medical care utilization and changes. *Archives of General Psychiatry*, *42*, 573-580.

Budman, S. (1992). *Models of brief individual and group therapy, in Managed Mental Health Care: Administrative and Clinical Issues*. Edited by Feldman, J.L., Fitzpatrick, R.J. Washington, D.C. American Psychiatric Press.

Budman, S., & Gurman, A. (1988). *Theory and Practice of Brief Therapy*. New York: Guilford.

Burk, J., Summit, P., Yager, J. (1992). Outpatient management teams: integrated educational and administrative tasks. *Academic Psychiatry*, *16*, 24-28.

Consumer Reports. (1995, November). Mental health: Does therapy help?, 734-739.

Cummings, N. (1996). Does managed mental health care offset costs related to medical treatment? in *Controversies in Managed Mental Health Care*. Edited by Lazarus, J.A. Washington, D.C., American Psychiatric Press.

Davanloo, H. (1978). *Basic Principles and Techniques in Short-Term Dynamic Psychotherapy*. New York, Spectrum.

Dawes, R. (1994). *House of cards: Psychology and psychotherapy built on myth*. New York: Free Press.

de Shazer, S. (1982). *Patterns of Brief Family Therapy*. New York: Guilford.

de Shazer, S. (1988). *Keys to Solutions in Brief Therapy*. New York, Norton.

de Shazer, S., & Molnar, A. (1984). Four useful interventions in brief family therapy. *Journal of Marital and Family Therapy*, *10*, 297-304.

Donovan, J., Bennett, M., & McElroy, C. (1981). The crisis group: Its rationale, format and outcome. In S. Budman (ed.), *Forms of Brief Therapy*. New York: Guilford.

Drug Benefit Trends Survey Report. (1998).

Garfield, S. (1986). Problems in diagnostic classification. *Contemporary Directions in Psychopathology: Toward the DSM-IV*, edited by Millon, T., & Klerman, G. New York: The Guilford Press.

Gustafson, P. (1984). An integration of brief dynamic psychotherapy. *American Journal of Psychiatry, 141*, 935-944.

Klerman, G., Weissman, M., Rounsaville, B., & Chevron, E. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.

Kroll, J. (1993). *PTST/Borderlines in Therapy: Finding the Balance*. New York: Norton.

Kuder, A., Kuntz, M. (1996). Who decides what is medically necessary? in *Controversies in Managed Mental Health Care*. Edited by Lazarus, J.A. Washington, D.C.: American Psychiatric Press.

Layden, M., Newman, C., Freeman, A., & Morse, S. (1995). *Cognitive Therapy of Borderline Personality Disorder*. Boston: Allyn and Bacon.

Lazarus, A. (1995). Managed Care Practice And Psychiatric Deaths: Must We Assign Blame?. *Administration and Policy In Mental Health*, 457-461.

Malan, D. (1976). *Toward a Validation of a Dynamic Psychotherapy*. New York: Plenum.

Masi, D., Caplan, R. (1992). *Employee assistance programs, in Managed Mental Health Care: Administrative and Clinical Issues*. Washington, D.C.: American Psychiatric Press.

Patterson, D. (1994). Outpatient services, the managed care view, in Allies and Adversaries: The Impact of Managed Care on Mental Health Services. Edited by Schreter, R.K., Sharfstein, S.S., Schreter, C.A. Washington, D.C. American

Scholl, A., Pinto, D., McGuigan, J., Murgia, C., Luscian, C., Garner, C., & Chambliss, C. (1996). Psychiatrists' and Psychologists' Attitudes Toward Managed Care. *Resources in Education*, ERIC/CASS.

Schreter, R. (1997). Essential skills for managed behavioral health care. *Psychiatric Services, 48*(5), 653-658.

Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. New York: The Guilford Press.

Strupp, H., & Binder, J. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy.* New York: Basic Books.

Winegar, N. (1993). *Families in Society: The Journal of Contemporary Human Services.* Families International, Inc.